



STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Health Care Cabinet:
Delivery System Innovation Work Group

Monday, November 14, 2011
Meeting Minutes

Attendees: Co-Chairs: Patricia Baker and Patricia Rehmer; Mark Horton; Judith Stein; Alfreda D. Turner, Nneka Mobisson-Etuk; Ellen Andrews; Kate McEvoy; Robert Tessier; Sarah Kolb; Fredericka Wolman; Margaret Grey; Joanne Walsh; Margaret Smith; Jennifer Castillo; Mark O'Brien; Alexis Fedorjaczenko

Absent: Vicki Veltri; Nicholas DeVito

Welcome & introductions

Co-chairs Patricia Baker and Patricia Rehmer opened up the meeting by welcoming new attendees and members, introducing themselves, and allowing the various members in attendance to introduce themselves.

Approval of October 4, 2011 meeting minutes

The first matter of business was to discuss the minutes from the prior workgroup meeting on October 4, 2011. The co-chairs emphasized the importance of hearing presentations from the Comptroller's Office and Department of Social Services before putting forth the initial recommendations. As such, the co-chairs suggested requesting from the Health Care Cabinet an extension of deadline until January 2012 to put forth the initial recommendations. The workgroup moved to accept the minutes with these changes; seconded; no further discussion; the motion passed unanimously.

New Business

Co-Chair Baker introduced the interns and their presentation on innovating health care in Connecticut by building upon past recommendations and existing work. Co-Chair Baker reinforced the notion that, as the group hears from a variety of speakers, there is no need to reinvent the wheel. The group should work to identify the connective tissue and value of existing work and hone in on where to focus its energy and time.

Interns Mark O'Brien and Jennifer Castillo re-introduced themselves, and acknowledged fellow intern Nicholas DeVito with his substantive help in organizing the presentation. Mark began by discussing recommendations that have come from within Connecticut. The HealthFirst Connecticut Authority was charged with providing recommendations ensuring health care access for all Connecticut residents. Its recommendations focused on chronic disease coordination and management, health information technology and exchange, data collection and its analysis and use, and the health professional workforce.

The SustiNet board offered recommendations on a variety of health issues. SustiNet recommended aligning health information technology with current statewide and national efforts, incentivizing adoption of technology, setting standards of data use and reporting, and defining clear measurement goals. On disparities and equity, recommendations were made to collect and use data to document disparities and assess improvement efforts, define measurable objectives, and create an incentivized system incorporating care coordination, chronic disease management, and prevention. The recommendations from the SustiNet Advisory Committee on Patient-Centered Medical Homes focused on patient-centeredness, inclusivity, community integration, and flexibility. On preventive health, SustiNet recommended models of cost-effectiveness, flexible community interventions, an annual prevention plan, and identifying and eliminating access

barriers. On matters related to health care quality and provider payment, Sustinet recommended strong evidence-based medical decision-making, new models outside of the classic “fee-for-service”, and risk stratification.

Jennifer presented on the Governor’s Transition Working Group on Health, which issued recommendations on various health issues in Connecticut. The group suggested creating an independent coordinating authority to guide the development, and support the sustainability, of medical homes in Connecticut. Once again, emphasis was made on the importance of health information technology. The group also suggested developing a government agency to lead in the coordination and development of payment reform pilots to foster collaboration while maintaining competition.

The interns pulled out themes from these recommendations that would provide the framework for the rest of the presentation. Community and payment reform served as overarching themes. The sub-themes within that consisted of technology (as it serves quality and efficiency), care coordination, prevention, chronic care, and disparities.

Jennifer presented on current projects and initiatives in Connecticut. Focusing on technology, she discussed the ongoing work of Middlesex Hospital, e-Health Connecticut, Adhere Tx Corp., and Innovatient Solutions. These groups and organizations have developed or utilized technology to manage workflow, collect and exchange data, and improve communication, among many other things that result in increased primary care provision patient compliance, and improved patient outcomes. Jennifer discussed current efforts on patient-centered, coordinated care in Connecticut, introducing the work from ProHealth Physicians, Connecticut Early Childhood Partners, HealthyCT, and various certified medical homes. Prevention initiatives consisted of the Assuring Better Child Health and Development program and the Yale University Program on Aging. Both of these programs focused on identifying and eliminating barriers of access to preventive health services, particularly focusing on the vulnerable and underserved populations. Current efforts on chronic care in Connecticut include the Hartford Childhood Wellness Alliance and the Easy Breathing program. While the Alliance incorporates community collaboration to fight childhood obesity in Hartford, the Easy Breathing program focuses on cost-effective and evidence-based efforts to provide high quality asthma care to children. Finally, the Centering Healthcare Institute, Connecticut Center for Eliminating Health Disparities Among Latinos, and Connecticut Health Foundation were presented as current initiatives on disparities. These programs focused on coordinated care, with an emphasis on community collaboration and group support.

Jennifer made mention of future presentations from DSS and the Comptroller’s Office on their work on medical homes and other Connecticut initiatives at workgroup meetings in November and December. Nicholas DeVito will also begin putting together a database on federal funding related to health reform in Connecticut.

Mark summarized Atul Gawande’s article “The Hot Spotters” for the work group, which focuses on patients with the highest medical costs. The Camden Coalition in New Jersey used emergency room data to find high utilizers, resulting in better outcomes and reduced costs. Verisk Health is a data analysis company that finds high utilizers, allowing them to recognize trends and assess the impact of policy. The Special Care Center in Atlantic City increased patient access, cut costs, and improved patient outcomes by charging flat monthly fees and instituting open access scheduling.

Mark then presented on current innovation outside Connecticut. The Group Health Cooperative, Partners in Care Foundation, Rochester Health e-Access, and various state Medicaid programs have all used data and technology to increase access, support collaboration, reduce errors, and improve patient outcomes. St. Luke’s Texas Liver Coalition, Rush University medical Center, and Parkview Health were presented as examples of care coordination, demonstrating that coordinated efforts can significantly improve health outcomes by identifying high-risk patients and connecting patients to appropriate and necessary resources. The preventive work of Aqui Para Ti, Johns Hopkins and Michigan Health and Hospital Association, and the Northwestern Hospital Diabetes Collaborative focused on tailored preventive interventions, evidence-based treatments, and collaboration through health information technology to provide the best care for their patients. Jennifer discussed the results in the Diabetes Ten City Challenge and Community Health Educator Referral Liaison program, which showed that with the support and encouragement of chronic health care coaches, patient care must extend beyond the doctor’s office and hospital. Finally, the Charleston Area Medical Center, Chinese Women’s Health Project, and Children’s Healthcare Access Program suggested innovative solutions to improving the quality of care, access, and health outcomes of vulnerable populations and groups.

As it is an important part of the discussion, Ellen Andrews wished to acknowledge efforts that were not discussed in the presentation. For example, Connecticut's Medicaid Transformation Grant allowed for a successful cost-effective medication management program with the UConn Pharmacy and Connecticut Pharmacy Association. Ellen further clarified SustiNet's medical home recommendations, stating that while the group would ideally prefer more providers recognized as medical homes, it should not be at the expense of dumbing down the standards. SustiNet's recommendations should be thought of "carrots" to becoming medical homes and not as "sticks" to drive providers away.

In response to Co-chair Baker's invitation to the group to identify and introduce big issues and themes within current initiatives, so as to avoid getting myopic in its work, Judy Stein provided the example of Medicare's work on patient-centered medical care, specifically Connecticut's implementation of an Accountable Care Organization, also known as an "integrated care organization." She mentioned the importance of recognizing the discrepancy between coordinated care and managed care, as well as disease management and care coordination. Judy made note of two common misunderstandings about Medicare: (1) That it is a fee-for-service system, and (2) that the private plan system, Medicare Advantage, is less of a burden on taxpayers (it actually costs about 14% more than the traditional Medicare program). Judy remarked on the Yale University Program on Aging, stressing the importance of physical therapy and other "maintenance services" by referring to the Medicare "Improvement Standard." Judy then mentioned the difficulty in collecting observation data for hospital care and cost-sharing information as it improves access to care.

Given the extent and volume of existing materials, Kate McEvoy suggested focusing on available stakeholders to provide their expertise in rounding out the inventory of current initiatives and efforts. Regarding the future presentation from the Comptroller's Office and its work with ProHealth and the Hartford Medical Group, she looks forward to discussing the potential for adopting common health outcome metrics, as well as modalities for payment reform.

Bob Tessier thinks the ACO regulations and efforts by Medicare will likely produce the biggest change, as it will affect so many providers. Bob suggested that there is a lot to learn from Massachusetts's health care reform efforts, particularly its work on payment reform. In light of that, the Massachusetts Health Data Consortium will hold a 1-day workshop on payment reform updates next month.

Ellen Andrews mentioned the work she did with policymakers at The Council of State Governments conference. The report is available at <http://valueovervolume.org> and it provides some guiding principles on payment reform. Another resource is a NCQA webinar on developing an ACO recognition program.

Mark Horton echoed Ellen's point that organizing around some guiding principles and/or categorizing them will help the group better understand the landscape. Mark requested recognition of other work going on in Connecticut, specifically with Medicare or Medicaid. Reiterating Bob's comments, Mark commented on accountable care organizations as a concept that will be used more in the private sector, as the commercial sector is the largest part of the market.

Co-chair Baker responded that it would be thoughtful to consider both the public and private sector in order to identify the leverage points. She made particular mention of payment reform and the difficulty of sustainability with grant funding. Since fees are a proven practice, Co-chair Baker wondered how to imbed them in the system versus having to depend on grant funders. She mentioned the innovation fund through CMS, and its potential to scale up best innovative practices that show a return, independent of a vote from Congress.

Alfreda Turner asked for further information regarding percentages or other type of quantifier to ease the transition of innovation into Connecticut. Judy responded with a proposal to provide a report or presentation on CMA's analysis of the ACA regulations.

Margaret Grey reiterated that teams are the best way to provide care, particularly around chronic illness and preventive care. She also brought up the issue of scope of practice for nursing in Connecticut. Because chronic care management does not fall to a physician-led primary care home, and rather to a team providing that care, Margaret suggested the consideration of the nurse-managed health care model.

Joanne Walsh agreed with Margaret about the value that nurses provide to health care. She mentioned the work in home care in reducing hospital re-admissions, acknowledging the efforts by Mary Malor and Eric Coleman involving patient navigation, coaching, and community health starting in the patient's home.

Margaret Smith was concerned with the lack of attention that oral health receives in the current chronic care model. Oral health, decay, and periodontal disease, is a chronic disease and should be managed as such.

Mark Horton reiterated Alfreda's point that to the extent that the group can prioritize everything by its occurrence, percentage, annual numbers, and potential for savings, will help the group tremendously.

Vice President of CT Hospital Association

She suggested considering global health work, specifically delivery system innovation in both developing countries and other areas in the western world. She pointed out a comparative effective data exchange used in the United Kingdom that has enjoyed success in patient outcomes and cost savings. There are also many examples of HIV and TB coordinated care in the developing world that can be leveraged here in terms of a chronic disease care coordination model.

Next Steps

Co-chair Baker requested that the group think about how to move into initial recommendations and/or analyze some of the data that has been brought forth. She requested that the group submit to Africka (as.hinds-ayala@ct.gov) any resources or materials that are relevant to the discussion, particularly on payment reform.

Alfreda suggested a development of a timeline that can help the group meet identification and research goals.

Public comment

Co-chair Baker opened up the floor to comments from the public. There were no public comments.

Adjourn

Meeting adjourned by Co-chair Baker.